STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 27 at a doctor visit. Interview with E3 on 6-8-06 and 6-13-06 indicated that he did not document monitoring and follow up for the noted health care issues, did not always see clients when they came home from the ER or hospital, was probably shown the policies upon hire, but did not know all the policies and spent a little bit on one afternoon going over policies and procedures but no specifics were given. E3 said that he was new at the facility and had been on his own as RN consultant at the facility since 12-05. He said that the Director of Nursing had a training check list that she went over with him during orientation.. E4, Director of Nursing said in interview on 6-13-06 at 11:30 AM that she was probably vague as to what was required for documentation by nursing when she trained E3. She said that the orientation check list was general. E3's " Inservice Check List" completed 2-17-06 includes many issues with personnel policies and does not specify job duties for the RN consultant. E4 said that the facility has very few medical policies and procedures and will have to up date them, as well as evaluate how new nurses will be trained / oriented.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.1210b) 350.1220h) 350.1230b)3)6)7)c)d)e)f)g)	W9999		

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W9999	Continued From page 28 350.1610a)b)c)3)e) 350.1610f)g)h)1)2) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services h) The facility shall maintain effective arrangements through which medical and remedial services required by the resident but not regularly provided within the facility can be obtained promptly when needed. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 6) Development of a written plan for each resident to provide for nursing services as part of	W9999		

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W9999	Continued From page 29 the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications. Section 350.1610 Resident Record Requirements a) Each facility shall have a medical record system that retrieves information regarding individual residents. b) The facility shall keep an active medical record	W9999		

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W9999	Continued From page 30 for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. c) Record entries shall meet the following requirements: 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports. e) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. 2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or habilitation services, shall be included in the resident's progress record when the recommendations pertain to an individual resident. f) A medication administration record shall be maintained which contains the date and time each medication is given, name of drug, dosage, and by whom administered. g) Treatment sheets shall be maintained recording all resident care procedures ordered by	W9999		

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W9999	Continued From page 31 each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. h) The records maintained for each resident shall be adequate for: 1) Planning and continuously evaluating each resident's habilitation program, 2) Furnishing evidence of each resident's progress and response to the habilitation program, and Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations are not met as evidenced by the following: Based on observation, interview and record review, the facility failed to provide clients with nursing services in accordance with their needs for 4 of 4 inside the sample (R1, R2, R3 and R4) when they: a. Failed to assess, monitor, follow up on, and document injuries, and monitor acute and ongoing medical issues for R1, R2, R3 and R4; and failed to serve and monitor the prescribed therapeutic diet for R4 who was at risk for aspiration and who had a history of pneumonia. b. Failed to monitor ordered blood pressures and weights for R1 and R3 .	W9999		

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W9999	Continued From page 32 c. Failed to teach and coordinate health care services with direct care staff. d. Failed to have a system in place to ensure health care policies are developed and implemented and nurses are taught these policies. Findings include: 1. There is no evidence of monitoring or follow up for ongoing Cellulitis and open area of R1's left leg or for cellulitis of R2's cellulitis of the elbow and groin rash. R1's physician note dated 4-25-06 states R1 is a 26 year old female with a diagnosis that includes Hypothyroidism, Seizure, Bronchial Asthma, Exogenous Obesity, Moderate MR [Mental Retardation], Peripheral Edema with Superficial Varicose Veins, Onychomycosis of toenails. An Admission Face Sheet includes additional diagnosis of Constipation, Premenstrual Dysphoric Disorder and Bi-Polar Disorder. R1 was admitted to the facility on 3-27-06. R1, according to a nursing note written by E3, RN, dated 4-17-06 [no time given], was taken to the Emergency Room [ER] for for "increased swelling to the left leg. Diagnosed with Cellulitis [left] leg. Script for Cipro sent to pharmacy." The nursing note does not indicate the time R1 went to the ER [on 4-16-06], how she was transported (she was taken by her mother), or any other instructions that were noted on the discharge instructions. The typed instructions noted to keep the leg elevated and to apply warm compresses 4 times per day. The nursing note	W9999		

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W9999	Continued From page 33 does not indicate when symptoms started, the part of the leg that was swollen, if there was redness, heat, fever or any other assessment before or after the ER visit. There is no evidence of any follow up by the direct care staff or nursing staff for the Cellulitis to the left leg. Interview with E6, direct care staff, on 6-9-06 at 10:15 AM, R1's leg was swollen the day after this ER visit from her knee to her ankle - with her ankle being "really swollen." She said that R1's leg was red and she did not see a sore that day on her leg. E6 said that she saw R1 picking at a sore on her leg a couple of days later at mid shin in the front of her left leg. She said when she called the nurse, the nurse said to put antibiotic ointment and a bandage on it. E6 said this should have been documented on the medication administration record. There is no documentation of the sore in the chart or the medication record, the call to the nurse, evaluation by the nurse or the treatment recommended by the nurse in R1's record, communication log or medication record. E6 said the sore at the front of R1's left leg was about the size of a quarter and almost as deep as a dime. She said the leg never "went totally back to normal" after the first ER visit on 4-16-06. E6 said there was no documented monitoring or follow up done by direct care staff for R1's cellulitis or sore on her left leg. An incident report was noted for R1 for 5-18-06 at 7:30 AM that said she had scratched the front of her left leg and it was bleeding. The "symptoms" stated there was swelling, bleeding, itching and redness. With R1's cellulitis diagnosis, there is no evidence of evaluation, monitoring, treatment or follow up for the bleeding scratch. The	W9999		

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W9999	Continued From page 34 incident report showed that E3 and E5 were notified of the injury at 7:30 AM on 5-18-06. E3 signed the report and dated it 5-17-06 (wrong date?) but put no note or observation of the injury on the report. There is no further mention of R1's leg until the next nursing note written by E3 and dated 5-29-06 [no time noted] states, "Taken to ER for increased concerns about swelling and redness to [left] leg. Again diagnosed with cellulitis. Placed on Zithromax and Bactroban ointment. Also ordered Epsom Salt compresses and to keep leg elevated. [R1] ambulating and will not keep leg elevated for long period of time. Also has tendency to pick at sores on leg..." This is the first mention of sore[s] on R1's leg in R1's record. There is no documentation in R1's record by direct care staff regarding R1's leg, sores, site or description of the sores or severity of swelling of the leg. A note written in the direct care staff [not signed or identified] communication log (information shared between shifts) had an unsigned entry dated 5-29-06 with no time noted. The note said that [R1's] "dad called expressed his concern about the sore on her leg, said its worse than ever and wanted to know if we were doing anything about it. Said he might have to take her to the ER. I called the nurse and [E5] to inform them about the situation..." An "On-Call Nurse Log" shows that a staff [with E7's initials] called the nurse at 12:30 PM on 5-29-06 to "express how he felt about her leg being worse than ever." The nurse instructions written by E7 said to "tell him if he takes her [R1] to ER to bring all copies back."	W9999		

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W9999	Continued From page 35 There is no evidence the nurse evaluated R1's leg following the ER visit. There was no evidence what steps were taken to ensure R1's leg was elevated or monitored. There is no referencein the nursing notes indicating evaluation or monitoring of R1's leg. R1 was again taken to the ER by her mother on 6-1-06 according to a nursing note written by E3 [no time noted]. "Mother apparently not satisfied with current treatment and appearance of left leg. Give another script for Septra DS, but mother returned with no discharge orders or prescriptions from ER visit. There is no reference in the nursing notes as to the appearance of the left leg that was referred to in the 6-1-06 nursing note. There is no evidence the swelling or open area of R1's leg was measured, drainage monitored, or otherwise evaluated for healing or response to treatment. Z3's physician note on a consult sheet dated 6-5-06 states that there is significant improvement with healed ulcer and to continue with Lasix, septra and periodic elevation (of legs). The nurse, E3, mentioned in a 6-5-06 nursing note [no time noted] that "open area appears to be healing" and the left leg remained swollen, but there was a noticeable decrease in redness. This is the first mention of an open area, healing, redness or amount of swelling in the nursing notes. There is no indication what part of the leg was red or swollen or the site or size of the sore. A note written 6-8-06 by E3 [no time noted] states there was "no redness seen to the left leg today during visual inspection. Small open area to left leg from apparent behavior incident from	W9999		

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W9999	Continued From page 36 previous evening. Area covered with a bandage. No redness, swelling or drainage seen at site." R1 was home on 6-8-06 during the survey from 9:00 AM to 4:30 PM. She was observed sitting in the living room, the front porch or walking around the facility. Staff were not observed to encourage her to elevate her legs or provide equipment to facilitate her legs elevation. She did not lay in bed to elevate her legs as recommended on a previous physician visit. R1's leg was observed in her room on 6-9-06 with E2, QMRP, at 3:35 PM. R1 said that her leg had not been elevated at the workshop all day. The lower leg was beet red and swollen, with the left ankle being more swollen that the right. There was an open superficial sore about the size of a nickle at the front of her left leg. The area was covered with a small latex bandage. The medication record shows that R1 is still receiving medication (Bactroban) on the sore. E2 verified that the lower leg was red and swollen at the time of the observation. E3 said in interview on 6-9-06 at 4:00 PM that apparently the area had been scabbed over, but R1 must have scratched the area open the previous evening. Per record review, R2 is a 37 year old male with a diagnosis that includes Cerebral Palsy, Autism and self abusive behavior. R2, per observation, walks with Canadian crutches with an ataxic gait. A physician consult sheet dated 5-12-06 states the reason for referral: "Has abscess on left elbow and rash between legs around the crotch." The physician diagnosed the elbow as cellulitis	W9999		

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W9999	Continued From page 37 and Tina cruris. The doctor noted there was no drainage from the elbow and no need to culture (the elbow). He ordered Keflex 500 mg three times a day for 10 days and Lotrisone twice a day [for the rash]. A note written by direct care staff in the on call nurse log states on 5-11-06 that the nurse was called at 7:55 (AM or PM not noted) to inform that R2's "rash spreading." The nurse response was "needs Dr Appt ASAP." There is no evidence of nursing or direct care staff monitoring or assessment of the cellulitis or groin rash. There is no documentation as to the type of the rash or symptoms of the cellulitis, when the rash or arm infection started or response to treatment. E8, direct care staff, said at 3 PM on 6-13-06 that the Lotrimin ointment was given for 10 days and the rash was then clear. The last nursing note in R2's chart is dated 11-2-05. 2. There is no monitoring for R1's bruised and swollen right foot and a bruised back. A note in the direct care staff communication book states on 4-30-06 that R1's "foot is bruised and she has been complaining of it hurting. Notified nurse said to keep an eye on it and he will try to get here in the morn to look at it." There is no documentation in the nursing notes about the bruise or pain. There is no evidence of an incident report or assessment of the injury. Another note dated 5-4-06 in the communication log states "please look at [R1's] foot (right?) if it looks bruised and swollen worse than usual call [E3] the nurse and let him know. If not she has a	W9999		

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W9999	Continued From page 38	W9999		

chir [chiropractor] appt, tomorrow and they can take a look at it." E7, direct care staff, said on 6-13-06 at 1:30 PM, that when the note was written in the communication log the next shift would have called the nurse, but acknowledged there was no record of the call to the nurse. E7 said that the staff only document if they call the nurse who is on call and do not document calls to the regularly scheduled nurse.

There is no evidence of any monitoring or assessment of R1's bruised or swollen foot.

A note in the On Call Nurse Log dated 5-20-06 states that the nurse was called at 7:20 PM for a bruise on R1's back. There was no response. according to the log. There is no incident report, documentation in the communication log or nursing notes regarding the bruise.

3. There is no evidence of monitoring, assessment or follow up for R1 and R3's eye infections and R1's cold symptoms.

Per review of the Medication Administration Record, it was noted that R1 had antibiotic eye drops ordered on 5-18-06 to be given 4 times per day until 5-23-06. The label for the medication on the Medication Record said Sulfacetamide 10% eye drops instill 1 drop in right eye 4 times per day for 5 days. There is no telephone order or evidence of other physician order for the medication. There is no nursing note or other documentation as to what the medication was for, or response to treatment. E6 said on 6-9-06 that R1 had an eye infection. When asked if anyone else had an infection, she said that R3 was treated with eye drops.

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W9999	Continued From page 39 R3's Medication Record showed that he had Tobramycin eye drops to the right eye given for 5 days. The physician note dictated on 5-26-06, but not on site at the facility until 6-13-06 per the surveyor request, stated that there was no obvious drainage or fever "same problem among other residents of the same group home." He noted that R3 had injected, inflamed right eye conjunctiva. There is no evidence of nursing monitoring, follow up or response to treatment. There is no documentation as to how long symptoms or type of symptoms were present prior beginning medication or resolution of the cold symptoms.. The On Call Nurse Log dated 5-20-06 at 7:20 PM states that R1 has cold symptoms. The nurse response is "OK to give Allor-Chlor." The direct care staff communication log states on 5-20-06 that R1 received Allor-Chlor at 9:00 PM. There is no documentation of symptoms shown, or response to the medication. There is no information in the medication record as to the medication/dose or time the Allor-chlor was given. There is no information in the nursing notes regarding the symptoms, medication or resolution of cold symptoms. 4. There is no evidence of monitoring for R2, R3 ad R4 following hospitalizations and procedures. Per record review shows the last nursing note for R2 was dated 11-2-05 and states that R2 was referred to a surgeon for a mass of the right inner thigh. A surgical consult was done. Per interview with E6 on 6-9-06, R2 had a boil removed about that time at the hospital. There is no documentation of the boil other than a physician consult note dated 11-3-06 that	W9999		

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LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 40 ordered hot compresses and antibiotics if "it does not drain on it's own and does not improve, please call." The 11-2-05 nursing note said that Keflex was ordered. There is no indication how the mass responded to the ordered treatment or if the physician was called. The previous nursing note, dated 9-21-05, stated that R2 had an abscess removed from the right side at the hospital on 9-05. Again, there was no monitoring or follow up after the surgery. R3, according to his current Physician Order Sheet and History and Physical dated 1-3-06, is a 63 year old male with a diagnosis that includes Severe Mental Retardation, Asthma, Lower Extremity Edema, history of deep vein thrombophlebitis right leg, Benign Prostatic Hypertrophy, Chronic Venous Insufficiency with Varicose Veins and Post Phlebitic Syndrome. R3 has a urology consult note stating that R3 was to have surgery on 3-16-06 for a Cysto, Dilatation, BNC and possible TURP. A surgical note states R3 underwent a cysto with urethral dilation. The surgeon's note stated he found a "tight mid penile urethral stricture as well as bulbous urethral stricture. A follow up was to be arranged in 2 - 3 weeks. Discharge instructions from the hospital were for no lifting or straining for 72 hours, monitor for difficulty with voiding and excessive drainage from penis and call doctor. He was discharged with Darvocet for pain and an oral antibiotic. R3's physician order sheet shows that he receives a blood thinner (Coumadin 4 mg every AM), medication for hypertension and asthma, along with other medications.	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 41 There is no evidence of R3 being monitored for blood clots following his surgery (due to history of blood clots post operatively), bleeding due to the blood thinner medication, monitoring of his vital signs following his surgery or monitored for straining, difficulty voiding or drainage from his penis. There is no mention of the surgery in the nursing notes. The last nursing note for R3 is dated 12-28-05. R4 was observed at the facility during the survey. He was noted to be coughing with a loose cough. The staff at the facility said that R4 was home recovering from pneumonia. Review of R4's physician order sheet shows that he is a 61 year old male with a diagnosis that includes Profound Mental Retardation, Aortic Regurgitation and Dysphagia. His nursing notes are dated 1-16-06 (referring to an eye infection), and 4-14-06 stating that R4 returned from the hospital with a diagnosis of pneumonia, lungs clear and vital signs normal and that he was resting on the couch. There is no further evidence of monitoring of R4's pre or post hospitalization and no indication when R4 entered the hospital. A history and physical from a hospitalization was noted in R4's chart. The report states R4 was admitted to the hospital on 5-4-06 with the complaint that he has been having "progressive cough since he was discharged with no improvement and since yesterday, he has been coughing up more and they noticed he coughed up some blood, but they have not noticed any fever, no chills, no other symptoms." A chest X	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

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W9999	Continued From page 42	W9999		

Ray and CT of the chest showed pneumonia on both sides and a small right pleural effusion. During his hospitalization he received a bronchoscopy, a lung biopsy, a swallow study that showed some penetration with thin liquid. R4 was discharged on 5-15-06. There is a nursing note dated 5-15-06 (no time) stating that R4 returned from the hospital with "4 X Pneumonia." Vital signs were normal, lung sounds were coarse but clear and he had no apparent distress.
The nursing note stated staff were instructed to monitor closely for signs of respiratory difficulty including cough, wheezing, labored breathing and to give PRN nebulizer if respiratory difficulty. There are no further nursing notes and no evidence of monitoring by nursing or direct care staff.

R4 has a physician order for a mechanical soft diet with ground meat and a thickner to all liquids to honey consistency. During his lunch on 6-8 and 6-9-06, R4 was observed to be served a lunch that included lunch meat sandwich cut in bite sized pieces, dry crackers and his thickened liquids. He was observed to cough occasionally during the meal. Staff did not sit with him through his meal. He has no teeth and did not chew his food. The lunch meat was not ground. E7, cook and direct care staff, said on 6-9-06 at 1:25 PM that they only grind tough meat for R4 and other meat is not served according the diet manual for mechanical soft diet. E9, dietician, said in interview on 6-9-06 at 2:55 PM that R4 should have ground meat as ordered.

A repeat chest X-Ray done 6-9-06 showed that R4 still had infiltrates in his lungs. There has been no nursing follow up since 5-15-06 when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 43 R4 came home from the hospital. 5. Review of R1 and R3's record shows that they are to have weekly blood pressures. Additionally, R1 is to have weekly weights. Review of the medication record, where, according to E3, E4, E5 and E6, the weekly blood pressures and weights are documented, shows that since admission to the facility on 3-27-06 R1's weekly blood pressures have not been done. Vital signs were documented in R1's medication record on 5-1-06, but the area for the blood pressure (as part of the "monthly vital signs") was left blank. Additionally, there is no evidence that R1's ordered weekly weights have been done as ordered. Review of R3's record shows that his ordered weekly blood pressures have not been done since 2-06. It was verified by E3 that there is no evidence that the ordered blood pressures were done. 6. There is no evidence that the facility has a system to instruct, teach and monitor direct care staff to monitor for acute and chronic health concerns for the clients. Information given per phone as noted in the On Call Nurse Log is not transferred to any place to instruct other staff. Information documented in the nursing notes in R4's 5-15-06 nursing notes upon return from the hospital stating what direct care staff were instructed to monitor for was not transferred to any system to alert and train all direct care staff as to what to monitor for. There are occasional notes in the direct care staff communication book (not written by the nurse), that says what the nurse says. There are no written instructions from the nurse.	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 44 E7 said in interview on 6-13-06 at 1:00 PM that there are no specific directions given as to health care of the clients. She said that information put in the communication book is purged at the end of every month, so if staff were off for a few days and return at the beginning of the next month, they are not aware of any notes or observations made by other direct care staff. She said there is no ongoing documentation by the direct care staff for monitoring clients conditions. She said that usually the only things that are put in the communication book are things that may be different with the client, but there is no follow up or monitoring documented. This was verified by E2, RN and E3, Director of Nursing. E3 said in interview on 6-13-06 at 11:30 AM that the nurses keep their own logs of information that is communicated to them by the staff, that they communicate to the staff, but this information is not necessarily a part of the client or facility records. Client documentation books used to give direct care staff information about clients and their programs do not include information regarding needed ongoing or short term health monitoring information. 7. There is no system in place to ensure health care policies are are developed and implemented as evidenced by: The facility has a policy that states that it is mandatory for the nurse on call to provide in facility services within 12 hours in situations that include: When a person returns from a hospital stay; when they return from an ER visit; surgery or an	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 45 invasive procedures requiring general anesthesia or IV sedation. There is a procedure regarding contacting the nurse on call and if the nurse fails to respond, but there is no policy or procedure as to what type of follow up the nurse is to do initially or ongoing. There is no evidence that this policy was followed when R1 went to the ER on 3 occasions since admission on 3-27-06 and there is no way to determine when follow up occurred in the facility. There is no policy or procedure as to what the regularly scheduled nurse is to do in these situations. The facility Medical Guidelines policy adopted 4-3-06 state that: A. The nurse is to be contacted for following all client doctor appointments, tests or pre-op visits. The Medical consultant sheets are to be faxed to the nurse immediately or when a fax machine is available. This policy was not followed when the facility had to call physicians to have medical consult sheets for R1 faxed to the facility for R1 per the surveyor request during the survey. B. The nurse is responsible to see that all physician orders are carried out and to advise the employees as needed on where to obtain services. The policy was not followed when medical follow up was not provided for R1, R2, R3 and R4. C. The nurse is to document all pending appointments, tests, medical services or equipment needed and to follow up weekly until it is obtained. If after one week a medical appointment or service has not been obtained, the nurse will document the reason in the	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 46	W9999		

pre-approved format and notify the Director of Nursing and QSD [Quality Services Director]. This policy was not followed for R1 who had not been evaluated for hearing amplification as recommended, and for R2 who had no recommended podiatrist follow up 3 months after the recommendation was made by the physician/specialist.

D. The QMRP (Qualified Mental Retardation Professional)/RSD (Residential Services Director) team leader are to send releases of information to obtain medical information and results as needed. It is the nurse's responsibility to follow up on these results as recommended by the physician. E5, RSD, stated on 6-8-06 at 2:00 PM that the facility could not get information from various emergency rooms for R1 because they did not have a release of information for the hospitals. As of 6-13-06, this information had not been obtained for R1's ER visits.

There is no policy developed as to how nursing or direct care staff are to monitor and follow up on health issues, were, when and how documentation and health care instructions are to be done, who will monitor to ensure health needs are met, and how staff document notification of the regularly scheduled nurse.

The Director of Nursing job description states he/she is to review all labs and forward to the prescribing physician for review. R1's TSH was done 5-10-06 and was abnormal. There is no evidence that nursing reviewed the abnormal lab work with the physician. No medication was ordered for the abnormal thyroid test until 6-5-06 at a doctor visit.

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	14G256	A. BUILDING _____ B. WING _____	C 07/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 47 Interview with E3 on 6-8-06 and 6-13-06 indicated that he did not document monitoring and follow up for the noted health care issues, did not always see clients when they came home from the ER or hospital, was probably shown the policies upon hire, but did not know all the policies and spent a little bit on one afternoon going over policies and procedures but no specifics were given. E3 said that he was new at the facility and had been on his own as RN consultant at the facility since 12-05. He said that the Director of Nursing had a training check list that she went over with him during orientation. E4, Director of Nursing said in interview on 6-13-06 at 11:30 AM that she was probably vague as to what was required for documentation by nursing when she trained E3. She said that the orientation check list was general. E3's "Inservice Check List" completed 2-17-06 includes many issues with personnel policies and does not specify job duties for the RN consultant. E4 said that the facility has very few medical policies and procedures and will have to up date them, as well as evaluate how new nurses will be trained / oriented. (A)	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W 149	Continued From page 27 and completion of incident report forms. The facility will ensure that nursing will give treatment guidelines for staff to follow for injuries. The facility will ensure the HRC policy and procedures will be followed for injuries for investigating injuries of unknown origin. The facility will ensure the cored professional team will ensure all systems are accurately implemented. Although the Immediate Jeopardy has been removed, facility non-compliance remains at the time of the exit due to the facility dates of implementation and monitoring have not been completed.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.3240a)c)d) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.3240 Abuse and Neglect	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 28 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility neglected to take necessary measures to keep clients of the facility from harm when they failed to implement their policy to prevent neglect and abuse when R6 was found with multiple large and small bruises and self inflicted sores. The facility neglected to take steps to protect R6 from further injury with the potential to affect the remaining clients at the facility (R's 1 to 5 and R's 7 to 14) when the facility: 1) Failed to implement their policy and procedures for Accident Report Procedures and take corrective action to prevent further incidents when R6 was found with 1 large bruise and no monitoring or exam of her body was done until multiple bruises were brought to the facility's attention by R6's mother. 2) Failed to implement their policy for missing persons when R6 eloped from the facility. The	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 29 facility failed to notify the Department, and the guardian, and failed to document or have R6 assessed for injury upon her return to the facility. 3) Failed to implement the facility's policy to inform the client's representative/guardian immediately by phone and/or in writing and to notify the Department of significant events when R6 was found with a large bruise. Two days later R6 was found with many large and small bruises on her body. The family, Department, and specified administrative staff were not notified. 4) Failed to ensure the Human Rights Committee Procedures to review and investigate injuries of unknown origin were implemented. The facility failed to ensure administrative and supervisory staff were trained in the procedures for documenting, reporting, and monitoring for injuries of unknown origin. These failures resulted in R6 having ongoing episodes [from review of incident and other facility reports for June and July 2006] of having injuries of unknown origin, self injurious behavior of picking sores on her body, and ongoing verbal and physical aggression. The last incident report reviewed was dated 7-17-06 and showed 15 bruises (4 new and 11 old) on all parts of her body. Findings include: 1. R6's physician note dated 4-25-06 states R6 is a 26 year old female with a diagnosis that includes Hypothyroidism, Seizures, Bronchial Asthma, Moderate MR [Mental Retardation], Peripheral Edema with Superficial Varicose Veins. An Admission Face Sheet includes	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 30 additional diagnosis of Premenstrual Dysphoric Disorder and Bi-Polar Disorder. R6's record showed that she was admitted to the facility from her mother's home on 3-27-06. She lived at her mother's home for a few months after having moved from a previous group home. The facility's policy for the Human Rights Committee states all employees will receive initial training on the Department guidelines regarding prevention and reporting of abuse and neglect prior to beginning work and will be annually trained in prevention of abuse and neglect. The facility definition of ABUSE is "any physical injury...inflicted on an individual other than by accidental means....." The facility definition of NEGLECT is "...Any act or omission by ...facility or employee thereof that results in documented physical injury to an individual, the circumstances or nature of which would cause a reasonably prudent person to believe neglect ...by the facility has occurred. Consideration shall be given to whether the injury was repeated or preventable...." This policy states that the Committee is to review and investigate unusual incidents involving clients and to review and investigate injuries of unknown origin. The PROCEDURE states if an employee becomes aware of an unusual incident involving a client, the employee is to report the incident to the supervisor who is to "immediate report the matter, by telephone, to the Service Coordinator or designee." The Service Coordinator is E3, who is the chairperson of the Human Rights	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 31	W9999		

Committee. The immediate supervisor is to report immediately the matter to the QSD [Quality Services Director], E2, who is to immediately report by phone to the Vice President. The Vice President is to immediately report the matter by telephone and/or writing to guardian/representative of the client.

Upon review of an Incident Report dated 7-15-06, E7, direct care staff, found a large bruise on R6's left side at mid rib cage. Documentation on the incident report showed that E7 reported at 10:00 PM (5 minutes after the bruise was found at 9:55 PM) the bruise to the nurse, E11, and the supervisor, E12. The incident report was signed by E7 on 7-15-06 and by E4, Residential Services Director, on 7-19-06 [4 days after the incident]. There is no evidence the Service Coordinator or others were notified. There is no monitoring or follow-up to the bruise.

E7 said in interview on 7-21-06 at 3:10 PM that she did not see any other injuries on R6 but did not do a complete body check. E7 said that the nurse did not come to the facility to look at the bruise when she was called.

There is no evidence the large bruise was evaluated or documented by the nurse in the nursing notes or any other place in R6's record.

There is no evidence the facility implemented their system regarding injuries of unknown origin.

Per a written report by E2, Quality Services Director [QSD], E2 wrote that on 7-16-06, R6's mother came to the facility at 10:00 PM to "look [R6] over...is checking for bruises. The report states "Mom said '[R6] is not self-abusing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 32 making the bruises on her body. Either her father or someone had inflected the bruises on [R6].'" The mother suggested "internal cameras." There is no evidence that E2 reported this allegation to the staff indicated in the policy. There is no evidence that R6 was assessed by facility staff for injuries or bruises following the mother's allegation. On 7-17-06 an incident report was written by E8, male direct care staff. The report has a question for the time. The incident report shows by circles (on a diagram of a body) 15 bruises identified as 4 new bruises and 11 old bruises. The body diagram on the incident report shows bruises on the sides and back of R6's legs and on the front and back of her arms and buttocks. The report, signed by E8, states, "The QSD asked staff to fill this out so me and another staff checked her [R6] over." All areas on the back of the report, other than a witness identified as E7, are blank. It does not indicate a review by any staff, no nursing notes or assessment is noted. There is no documentation that the entities noted in the policy were contacted. The front of the report is signed by the Director of Nursing and E2 at 7:00 PM. The director of nursing made no notes or described the size, color, or location of the bruises. There are no nursing notes or documentation in R6's chart regarding the number, location, size, or color of the multiple bruises on R6. The nursing notes make no mention on 7-17-06 of the bruises.	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 33 The notes written by E13, RN, on 7-18-06 state R6 has unknown bruises to arms and continues to pick sores. No further mention of number location or description or healing of R6's bruises. R6 was observed at the facility on 7-18-06 when the surveyor was conducting another facility survey activity. The surveyor saw a large long purple bruise on R6's right inner thigh. The large purple bruises identified on the incident report were seen on R6's leg because she was wearing shorts. E2 was asked about the bruises on 7-18-06. E2 said it was being investigated. The incident report does not include the bruise on R6's inner thigh. However, photographs taken by Z6 on 7-17-06 show the bruise on R6's right inner thigh. There is no evidence the facility notified the identified staff as stated in the policy, and no evidence that an accurate body check was completed. E3 is responsible for all investigations, per her interview on 7-25-06 at 12 PM. The policy states the Committee is responsible for investigations, and that the Committee is to meet within 24 hours of receiving a reported allegation of abuse. E3 said she was not aware of that requirement and said that it would be impossible to implement. E3 also said that she had not been made aware of the incident report dated 7-17-06 and was surprised to see the number of bruises on R6.	W9999		

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W9999	Continued From page 34 Additionally, she had not been made aware of the large bruise on R6's side from 7-15-06. The allegation of abuse made by R6's mother was made at 10 PM on 7-16-06 to E2. E2 said in interview on 8-3-06 that she called the administrator and E3 as soon as she could get R6's mother out of the office. E3 said that she was not informed of the incident regarding R6's bruises/allegation of abuse until the morning of 7-18-06 by E2. The administrator, E1, said that she was notified but there is no documentation as to when she (or E3) was notified. Item # 21 of the policy states the "Vice President (E1) and/or the QSD (E2) will take corrective action(s) as necessary to prevent the recurrence of violations of ...abuse, neglect...of unusual incidents. There is no evidence that any corrective action was taken to monitor or prevent further bruising. The investigation, completed in 1 day, stated the bruising was from her maladaptive behaviors and daily aspirin and did not include interviews with all staff who may have given R6 a bath or had been working at the facility in the days prior discovery of R6's bruising. R6 was taken home with her father and step mother on 7-18-06 following the allegation of abuse and returned to the facility 7-25-06. E4 did a body check with the surveyor with R6's permission in her bedroom at 2:55 PM. E4 documented sores and bruises found on R6 on a body diagram. E4 verified that on 7-18-06 R6 had a bruise on her right inner thigh (now	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

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LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 35 healed). The body check observed on 7-25-06 resulted in finding 11 bruises noted on R6's arms, legs, side, and lower abdominal areas under her fatty apron. E4 said she had not done a complete body check including under her fatty abdominal apron prior to that date. The examination also showed areas of open sores. A sore that was on the leg with cellulitis now has four additional sores in the area. Scratches were noted on R6's back - she said her back itched. Z2 stated in interview on 7-21-06 at 1:50 PM that he was shown a "gruesome bruise" on R6's side of her stomach (the same area observed on 7-15-06). R6 told Z2 that someone hit her and said the person who fixed her lunch did it. Z2 said that R6 was wearing shorts and he also saw a very large purple (size of soft balls) bruises on the back of her legs and had scratched a bruise on her arm. Z7 said in interview on 7-25-06 at 3:30 PM that she had known R6 for at least 2 years and has never seen injuries or behavior before that she is showing at home. Z7 said she had never seen "something like this in all my experience." She said that it looks like abuse and looked like R6 has "been in a car accident." E4 said on 7-25-06 at 2:55 PM that R6 has been home and the facility could not monitor her when at home, but also stated that no measures were put into place when R6 returns to the facility. As of 7-25-06, the facility has no evidence that measures are in place to monitor R6 for injuries. There is no evidence provided to the surveyor	W9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 36	W9999		

that the facility has made any further attempts to find the source of the bruising and protect R6 from further injury.

Per review of incident reports from 6-7-06 to 7-18-06, the maladaptive behaviors documented by direct care staff included cursing, hitting walls, throwing her clothing on the floor, occasionally physical aggression toward a peer, picking sores on her body, and property destruction.

Per review of the Individual Habilitation Plan [IHP] for R6 dated 4-20-06, it does not address the maladaptive behaviors as documented by direct care staff. Staff document that they send R6 to her room and won't let her come out [of her room] until they say so. The direct care staff documentation dated 6-27 and 6-28-06 show that from periods lasting more than 1 1/2 hours, R6 would yell, hit walls, curse at staff, slammed her door, tore paper and threw on the floor. The staff repeatedly sent her to her room. The staff documented, "There aren't any program consequences" and R6 continued to "pick her sores" - at one time taking a soda tab and creating a sore on her arm while on the front porch.

R6's (IHP) dated 4-20-06 states "R6 exhibits occasional maladaptive behaviors in the home and community."

The COMMENTS section of the IHP states R6 receives Ability and Naltrexone to assist in controlling her inappropriate behavior (not identified) as targeted in Program 1.1. Upon review of Program 1.1, it is for her money management and banking skills.

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 37 Review of incident reports and behavior documentation sheets from 6-7-06 to 7-18-06 show that R6 had 18 incidents of picking sores, hitting/punching walls, hitting a window, throwing a plant, pushing a peer causing her to fall, cursing at staff and non compliance with staff directions to go to her room for maladaptive behaviors. R6 has had ongoing Cellulitis (infection) on her left lower leg since April 2006, per review of her chart, from picking sores in the area of the Cellulitis. The program director at the workshop stated on 7-25-06 at 11:00 AM that R6 loves to keep busy at the workshop and never exhibits behaviors at work. R6's father and step mother stated in interview on 7-25-06 at 3:50 PM that R6 does not display maladaptive behavior at (their) home and that this behavior is unusual for her. E4, Residential Services Director [RSD], stated on 7-21-06 at 3 PM that no behavior program had been written for R6. She was not sure who was to write the program but thought she was supposed to write the program. She also stated that she did not know how to do this or the regulations regarding behavior plans and would probably have to write the behavior program from looking at another client's behavior program. E4 said that the HRC has not met yet (a meeting is scheduled). The Committee failed to follow their policy to take corrective action to monitor and develop effective active treatment strategies to address R6's maladaptive behaviors to ensure her health and safety.	W9999		

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W9999	Continued From page 38 2. Based on review of incident reports and interviews, the facility neglected to implement their policy when R6 eloped from the facility. An incident report dated 7-9-06 at 3:35 PM states that R6 was sent to her room for cursing and yelling at peers. The report stated R6 "left out or sneaked out through side door. I was preparing to pass meds. Other staff was watching other [clients]. She went out side door on parking lot side. But she went around the blind side of the building. I went to check on her in her room. I looked out front window and noticed [R6] was over there at the Mexican restaurant outside on their patio. I went over there and got her. I asked what she doing over there? R6 replied getting her a drink. I asked what kind of drink. [R6] responded to me and said a beer you d--- fool what do you think." The report also said "she [R6] said I'm not taking a shower or doing anything." . The incident was reported to the supervisor at 3:36 PM. The response was to "keep a very close eye on her all day." The report includes no investigation, nursing notes/assessment, indication of how long R6 was gone from the facility, if anyone was on the patio with R6 at the restaurant, or any other indication that action was taken to ensure R6's health and safety. The report was signed by E2 and E4 on 7-11-06 and by E1 on 7-12-06. #7 of the policy states "all incidents of missing residents will be investigated by the Service Coordinator." E3 said on 7-25-06 at 12:00 PM that she was not aware of the elopement - that nobody informed	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

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W9999	Continued From page 39 her of the incident and that the incident of R6's elopement was not investigated. The report was signed by E4 [RSD] on 7-11-06, E13 [RN] on 7-11-06, and by E1 [Administrator] on 7-12-06. There is no evidence of evaluation, and recommendations to prevent further elopement activity. There is no evidence of analysis of staffing / environment to ensure corrective measures were taken. E3 did not question how R6 got out of the door without staff hearing the door alarm. R6's IHP of 4-20-06 states that R6 will show maladaptive behavior {unidentified) in the community. The area of Capacity for Independent living states R6 has poor pedestrian and self preservation skills and does not look before crossing a street. The area of Self Direction states she may or may not ask for directions if lost. R6 is on a training program to say her address. The program was not implemented in May and June data shows 0 progress for this goal. The facility neglected to ensure R6's safety when the incident was not investigated as per their abuse/neglect policy. 3. Based on review of incident reports, client record documentation and interview, the facility failed to notify guardians, families, and the Department of significant incidents and allegations of abuse. Review of incident reports for June and July have no documentation that the guardian or the Department was notified of any of the injuries or elopement for E6.	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 40 Z6 on 7-25-06 at 3:50 PM said that they were not notified of R6's bruises/injuries and would have been prepared if the facility had given notification of the injuries. There is no evidence at the Department that the injuries/incidents that were significant were reported. The facility policy for abuse and neglect (#13) and Elopement policy (#6) both state the facility is to be notified by the QSD or designated person. #5 of the abuse policy states the Vice President or designee shall immediately report by telephone and/or in writing to the guardian/representative. E1, Vice President, stated in interview on 8-2-06 at 1:30 PM that she does not know the whole process of investigations and who does what and when it is done. She said that she did not notify the guardian of R6 of the injuries/elopement and all bruises noted. E2, QSD, stated in interview on 7-21-06 at 1:00 PM that she does not know anything about incident reports, investigations, and did not notify anyone/Department of allegation of abuse and multiple injuries observed on R6. The facility neglected to ensure administrative/supervisory and professional staff who were notified, reviewed, and signed the incident reports/significant incidents assured the facility policies were implemented implemented and guardians/representatives and the Department was notified of significant events. 4. The facility failed to ensure the Human Rights	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 41 Committee Procedures to investigate injuries of unknown origin were not implemented. The facility policy for "Human Rights Committee Procedures - ICF / DD" states the function of the Committee includes to Review and investigate unusual incidents involving clients (#4) and to review and investigate injuries of unknown origin (#5). The policy states (#11) that "Pictures will be taken or diagrams drawn, of the location(s) involved and injuries sustained, and other evidence will be secured and collected, as needed...." The policy further states that the Service Coordinator [E3] will interview and gather written statements from ...all witnesses. The policy states (#19) that after the Human Rights Committee has met, the Vice President [E1] shall make the final decision as to appropriate action to be taken and/or if the Vice President disagrees with the recommendations of the Committee, to take the issue to the Executive Vice President [E10]. E3 said in interview on 8-3-06 at 1:40 PM that R6's bruises were reported to her on 7-18-06. The allegation of abuse was made on 7-16-06 to E2 at 10:00 PM, according to the. written statement from E2 dated 7-17-06. An incident report was completed on 7-17-06 at an unspecified time by E7 and E8, direct care staff, at the direction of the QSD [E2]. The time the incident report was written is not identified, but the area for notification of supervisor states	W9999		

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	14G256	A. BUILDING _____ B. WING _____	C 08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS AND CLARK MANOR	56 CHOUTEAU TRACE PARKWAY PONTOON BEACH, IL 62040

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W9999	Continued From page 42 E2 was notified at 4:00 PM and Nurse was notified [E14, Director of Nursing] at 7:07 PM. 14 bruises were identified on the incident report - 4 new and 11 old - on her legs, arms, torso and buttocks. None of the bruises on the report identifies the size or color of the bruises. There is no report of the sores that were on R6's body that were reported in documentation. A bruise on R6's inner right thigh was seen by the surveyor on 7-18-06 while at the facility and identified by E4 on 7-25-06 at 2:55 PM as having been present the previous week and observed by Z6. The bruise was not identified on the undated incident report. During the interview with E3 on 8-3-06 at 1:40 PM, E3 said she conducted her investigation on 7-18-06 into the bruises found on R6's body. Color photographs dated 7-18-06 were taken of 4 large bruises - about the size of a softball. The pictures were identified as "Right Leg; Right rib area; Left leg - back of left leg; back of right upper arm. Some of the pictures are not clear and do not identify the exact location of the bruises. E3 said the photo identified as the right leg was actually the side of the lower right thigh. The left leg was actually at the calf area. None of the other bruises (15 bruises noted on 7-17-06 incident report) were photographed or identified in E3's investigation. None of the sores on R6's body were noted or investigated by E3, per her report and interview. E3 said in the interview that E4 showed her which bruises to photograph and she went to the facility to take the photographs of R6's bruises. E3 said that maybe she made the assumption	W9999		

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W9999	Continued From page 43 that there were no more bruises. E3 did not do a body check or ask for a medical assessment to see if there were more injuries. The sores on R6's body on her face, arms and leg were visible, but there is no evidence E3 inquired or investigated the source of the sores. E3 said she was not aware of the incident report signed by the director of nursing and E2 on 7-17-08 that shows 15 bruises on R6. When E3's investigative case summary was written, it was dated 7-19-06, but does not state when the investigation was initiated. The Summary states E7, direct care staff, noticed a bruise on R6's right side when assisting with a shower on 7-15-06. There is no written statement or interview from E7 regarding the bruise, other than an incident report. E3 said she did not investigate the bruise on R6's side found 7-15. The summary includes statements from 2 workshop staff stating R6 has no behaviors at workshop and wears long pants, so bruises were not observed and the only self inflicted sores were noted on R6's face and legs. There is no interview or written statement from Z8 and a workshop program director. The summary includes a statement from E2 that R6's mother came to the facility at 10:00 PM on 7-16-06 and did a body check on R6 and found no bruises, although there was a documented large bruise found on R6's side the previous evening. The summary continues that on 7-17-06 R6's mother took E2 to R6's room to show E2 all the bruises found on R6. E2, per the summary, went to the room where the mother showed E2 several bruises.	W9999		

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W9999	Continued From page 44 This does not correspond with E2's written statement of 7-17-06 that does not make any mention of going to R6's room or seeing the bruises, or if "several bruises" were seen with R6's mother, which bruises were seen. The written report talks more of R6's medical condition of swelling of R6's left leg and medical recommendations. E2's written statement, however, did state that R6's mother made an allegation of abuse by R6's "father or someone had inflicted the bruises." The allegation of abuse was not mentioned in E3's report, and there is no evidence the allegation was investigated. The only direct care staff interviewed were E5, E6, E15, and E16. The direct care staff who worked on 7-15 or 7-16-06 include: E9 worked AM's on 7-15 and 7-16. E17 worked 2 - 10 PM on 7-15, 7-16 and 7-17. E21 worked 6AM - 2 PM on 6-16-06. E20 worked 2 - 10 PM on 7-16. E8 worked 2 -10 on 7-17. E3 verified in interview on 7-25-06 at 12:00 PM that only the staff identified on the report were interviewed, and no staff were interviewed about the bruise found on 7-15-06. E5 stated in her investigation statement taken by phone by E3 on 7-19-06 that R6 "has behaviors everyday where she throws herself against furniture and she flops herself down in a chair very hard." The behaviors of "throwing herself against furniture" are not documented in any incident report or incidental charting.	W9999		

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W9999	Continued From page 45 The following staff interviewed stated they had never seen R6 throw herself against furniture but "flops down" in chairs: E4 on 7-21-06 at 3:00 PM. E6 on 7-25-06 at 2:15 PM. E7 on 7-21-06 at 3:10 PM. E9 7-21-06 at 1:48 PM. E5, who had made the statement to E3 about R6 throwing herself against furniture, said in an interview on 8-2-06 at 10:30 AM, that R6 flops down in chairs hard, but has never seen R6 throw herself against furniture; and said she guessed "I worded it wrong," but R6 will bang her head against a wall when sitting and will hit a wall with her fist or hand. E5 said she has not documented incidents when R6 has hit her head on the wall when sitting. E3 said in interview on 8-3-06 at 1:40 PM that she did not verify the information given by only one staff to come to the conclusion that she got bruises all over her body from throwing herself against furniture. The only documented self abusive behavior R6 has demonstrated is picking at sores on her skin. No other self abuse has been reported or documented. R6 requires assistance with her bathing, but E3 did not focus the investigation to ask staff who should have seen her at bath time if she had been observed/supervised at bath time and if bruising/injuries were observed. E3 verified she did not interview R6's mother, father (who had taken her for an outing on 7-16-06), her step-mother, psychiatrist, or attending physician, and completed the	W9999		

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W9999	Continued From page 46 investigation in one day. The investigation conclusion states, "It is a documented fact that [R6] is self-abusive, and that she bruises easily because of the aspirin she takes daily. It is also documented that [R6] has displayed various self abusive behaviors such as throwing her self into furniture, hitting door frames, and flopping down on furniture. When asked, [R6] told staff that she received the bruise on her right side when she ran into the kitchen door...Based on the information gathered during this investigation, it is impossible to conclude where or how [R6] received the bruises on her body. This investigation is considered closed at this time unless additional information becomes available." E3 said in interview on 7-25-06 at 12:00 PM that she concluded that the aspirin caused the bruising because E4 told her aspirin caused bruising. E3 did not verify this with any medical staff and did not know the dose of aspirin taken by R6. Per interview with Z1 on 8-2-06 at 10:45 PM, the small dose of baby aspirin taken once a day would not cause the large bruises noted on R6, and no one from the facility asked if the small dose of baby aspirin could cause such large bruising. There is no evidence the Human Rights Committee met as a team to discuss the investigation [dated 7-19-06] and conclusion or brought findings and recommendations to the Vice President [E1] to make the final decision as to appropriate action required as stated in the Human Rights Committee Policy.	W9999		

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W9999	Continued From page 47 While at the facility, the Surveyor was made aware of an allegation of abuse on 7-25-06 alleging that E9 abused R6 causing the above mentioned bruises that were found on R6. Notification made to the Department by fax dated 7-24-06 states that R6's mother reported to E4 on 7-24-06 that R6 was "grabbed, hit and kicked on numerous occasions by day staff, E9." E4 reported the allegation to E1 and the Human Rights Committee. E9 was placed on mandatory leave of absence pending an investigation. A follow-up to the allegation (dated 7-28-06 and faxed to the Department on 7-28-06) reported on 7-24-06, states that the allegation was made on 7-24-06 According to the follow up report of the allegation, the Human Rights Committee met on 7-28-06. Per the "Investigative Case Summary", dated 8-3-06, the investigation was started at the facility on 7-25-06 (three days after the allegation) with the summary being written on 8-3-06 (12 days after the allegation) and signed by E1. There is one statement from the RN [nurse trainer] that is dated 8-4-06 that states the pharmacist stated since she "is on several medications that have side effects that could impact on this. The blood tests would be completed with guardian approval (to test the clotting time of R6's blood). The results of the investigation will be reviewed when the tests are completed." The allegation states R6 demonstrated on her father through gestures on his body the methods in which she received the bruises and indicated on her father's body the areas in which the injuries were received. R6 kept saying the name	W9999		

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W9999	Continued From page 48 of E9. Prior to that when asked, R6 said she did not know how she got the bruises or would say staff did it or that the [staff] who made sandwiches in the morning. E9 worked the day shift and had not been interviewed in the previous investigation for the bruises found on R6's body. When asked to identify the staff via pictures of the staff (more than 13 photos), the investigation said that R6 could not identify the photo's by name. R6, per the report, said that "Rachel" caused the bruises. When at the facility, R6 told the surveyor on 7-25-06 that Rachel caused the bruises. There is no person named Rachel at the facility, and it is unknown who "Rachel" is. The report states E9 was on vacation the week of 7-17-06, when the first identification of the multiple bruises were noted and her last day was 7-16-06, so it was discounted that E9 could have caused the bruises because she was not there after 10:00 PM on 7-16-06. The facility report did not make a determination as to when the bruises occurred, only that the mother reported them to the facility on 7-17-06. The committee again made the recommendation for lab work to be done to check blood clotting. This the same recommendation that was made in the first investigation which concluded on 7-19-06 for the multiple bruises. The tests were not done after the first investigation. The investigative case summary states that R6's attending physician told E4 that R6's mother revoked the release of information and no order between the doctor office and the facility so could not speak to the facility about medical issues nor	W9999		

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W9999	Continued From page 49	W9999		

could he give physician orders for R6. Per the physician office, R6's mother said that R6 no longer lived at the facility. There had been no discharge from the facility for R6, but she was on an extended stay at her father and step mother's home since 7-25-06.

The summary of the abuse allegation by E9 was dated 8-3-06 and did not include any statements or interviews from clients. There is no evidence that staff were asked specific questions regarding abuse alleged against E9, but only talked about the injuries. The nurse trainer gave a statement after the summary was written (8-4-06) and did not give evidence that she had examined R6. Some of the statements attributed to the 7-24-06 investigation were actually obtained on the 7-18-06 investigation and did not pertain to the abuse allegation involving E9.

Additional examples are available for the facility not investigating injuries of unknown origin as based on incident reports from June to July 21, 2006:

R6 on 6-20-06 had a bruise on her arm and a cut on her hand. She said that it was done on a box at the workshop. This was not investigated or validated by the facility. Z8 said in interview on 7-25-06 at 11:00 AM that on 6-20-06 E13, facility RN, was at the workshop and looked at the injury. He said that it was not injured on a box at the workshop, but was injured at home. No investigation was done regarding investigation with the workshop to see how R6 was injured with a cut on her hand and a bruise to her arm, or to verify that the injury occurred at the workshop.

R6 on 6-24-06 had 2 bruises on her right arm.

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W9999	Continued From page 50 She said that she got the bruises while fishing with her dad. There was no investigation as to how she obtained the bruises or any interview of R6's father was interviewed regarding the bruises. R6 on 6-30-06 had a scrape on her face. The report states "had a behavior, came to med room with blood on face, first aid given, has been fine since." The report was signed by E7, direct care staff on 6-30-06. There are signatures from the RSD and nurse on 7-3-06 and by the administrator/vice president/QMRP on 7-12-06. There is no evidence the source of the bleeding was investigated or documented. R6 on 7-9-06 eloped from the facility. There was no evidence of an investigation for the incident.)n 7-15-06 a large bruise found on R6's side. There was no investigation into the incident at the time. The report was written on 7-15-06 showed that E11, nurse, and E12, supervisor, were notified at 10:00 PM (5 minutes after the large bruise was found). E4, RSD, signed the report on 7-19-06. There is no evidence of investigation at the time or evaluation of the injury by the nurse. 5. The facility failed to ensure staff were trained in the Procedures for documenting, reporting, and monitoring for injuries of unknown origin. There is no evidence that facility staff are trained in writing and implementing the facility policy for completing an incident report as per facility safety policy. #6 of the policy states the staff member is to	W9999		

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W9999	Continued From page 51 complete the Incident Report form. All areas of the form are not completed regarding notification of staff. Regardless of validation, direct care staff state "no" for if the injury was of unknown origin. The Policy states the RSD/QMRP is responsible to record the information from the Incident Report form in the resident Chronological notes as well as follow up information. The Policy states the incident is to be placed in the resident's record. The current facility practice does not document follow-up on the incident report (except for occasional nursing instructions for first aid), and the incident is not consistently documented in the chronological notes. Vital signs are not recorded on any incident report reviewed for the 6 week interval reviewed. The procedure/instructions written on the Incident Report form states the report is to be turned to the RSD/QMRP before the end of the shift. There is no evidence this has been done since the RSD or QMRP is not always at the facility. There is an area on the Incident Report form to write the results of investigation (if injury of unknown origin). This was not completed in any of the reports reviewed. E3 said in interview on 7-25-06 at 12:00 PM that she will do an investigation into an injury of unknown origin depending on the severity of the injury/incident. She said that staff notify the supervisor of the incident, the supervisor will write the summary of the investigation, and the facility will notify her if she needs to do an investigation.	W9999		

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W9999	Continued From page 52 E2 said in interview on 7-21-06 that she did not know anything about incident reports or the process of the report. She said on 8-2-06 at 1:20 PM that she did not know the whole process of investigation - who does what and when. E2 is the Quality Service Director to ensure quality of facility records for the corporation's homes and has been at the facility for a few months. There is no evidence that the facility re-trained staff after Incident Report forms were incomplete, or in error or re-trained staff when there was no evidence that injuries of unknown origin were investigated based on the information from the incident reports. The facility neglected to have a system that protects clients from neglect and abuse by their failure to implement policies and procedures and by their lack of effective strategies to prevent and monitor for abuse and neglect and by their failure to take corrective action when injuries were found on clients at the facility. The deficiency practice in client protections from abuse and neglect has the potential to affect the other 13 clients who reside at the facility (R's 1 to 5 and R's 7 to 14). (A)	W9999		